4. PROGRAM REGULATIONS

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series MENTAL HEALTH CENTER MANUAL	SUBCHAPTER NUMBER AND TITLE 4 PROGRAM REGULATIONS (130 CMR 429.000)	PAGE 4-1
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429.401: Introduction

130 CMR 429.000 establishes requirements for participation of mental health centers in MassHealth and governs mental health centers operated by freestanding clinics, satellite facilities of clinics, and identifiable units of clinics. All mental health centers participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations set forth in 130 CMR 429.000 and 450.000.

429.402: Definitions

The following terms used in 130 CMR 429.000 have the meanings given in 130 CMR 429.402 unless the context clearly requires a different meaning.

After-Hours Telephone Service — telephone coverage during the hours when the center is closed for members who are in a crisis state.

Autonomous Satellite Program — a mental health center program operated by a satellite facility with sufficient staff and services to substantially assume its own clinical management independent of the parent center.

Case Consultation — a scheduled meeting of at least one-half hour's duration between the clinical staff at the mental health center and other providers of treatment concerning a member who is a center's client. Other providers of treatment are professional staff who are not employed by the mental health center but who are actively providing care or treatment for the member. The purpose of case consultation must be at least one of the following:

(1) to identify and plan for additional services;
(2) to coordinate a treatment plan with other providers involved in the member's care;
(3) to review the member's progress; or
(4) to revise the treatment plan as required.

Core Discipline — one of the following disciplines: psychiatry, social work, psychology, or psychiatric nursing, most or all of which are represented by the professionals qualified in these disciplines who comprise a mental health center's core team.

Core Team — a group of three or more mental health professionals that must include a psychiatrist and one each of at least two of the following professionals: clinical or counseling psychologist, psychiatric social worker, or psychiatric nurse. The members of this group collaborate in developing a diagnostic evaluation and treatment plan for the patient, utilizing their particular skills, competencies, and perspectives.

Couple Therapy — psychotherapeutic services provided to a couple whose primary complaint is the disruption of their marriage, family, or relationship.

Crisis Intervention/Emergency Services — immediate mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, provided during all hours to clients showing sudden, incapacitating emotional stress.

Dependent Satellite Program — a mental health center program in a satellite facility that is under the direct clinical management of the parent center.

Diagnostic Services — the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan.

Family Consultation — a scheduled meeting of at least one-half hour with one or more of the parents, legal guardian, or foster parents of a child who is being treated by clinical staff at the center, when the parents, legal guardian, or foster parents are not clients of the center.

Family Therapy — the psychotherapeutic treatment of more than one member of a family simultaneously in the same session.

Freestanding Clinic — any institution licensed as a clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, s. 51, that is not part of a hospital and that possesses its own legal identity, maintains its own patient records, and administers its own budget and personnel. Such institutions include mental health centers and community health centers.

Group Therapy — the application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

Home Visits — crisis intervention, individual, group, or family therapy, and medication provided in the residence (excluding a medical institution) of a current member, when the member is unable to be served on the center's premises.

Identifiable Unit — a separate organizational unit that is located in a separate part of a clinic, and that is identifiable in its fiscal, personnel, and program elements.

Individual Therapy — psychotherapeutic services provided to an individual.

Long-Term Therapy — a combination of diagnostics and individual, couple, family, and group therapy planned to extend more than 12 sessions.

Medication Visit — a member visit specifically for the prescription, review, and monitoring of psychotropic medication by a psychiatrist or administration of prescribed intramuscular medication by a physician or a nurse.

Mental Health Center (Center) — an entity that delivers a comprehensive group of diagnostic and psychotherapeutic treatment services to mentally or emotionally disturbed persons and their families by an interdisciplinary team under the medical direction of a psychiatrist.

Mental Illness — mental and emotional disorders as defined in the current *International Classification of Diseases, Clinical Modification* or the American Psychiatric Association's *Diagnostic and Statistical Manual*, and manifested by impaired functioning in behavior, feeling, thinking, or judgment to the extent that the affected person, or someone else, can observe that the person affected is unable to fulfill reasonable personal and social expectations.

Outreach Program — a mental-health-center program located off the premises of the mental health center that:

(1) is located in the same Department of Mental Health area as the mental health center or in a contiguous area;
(2) is open to patients no more than 20 hours per week; and
(3) on a regular basis offers no more than 40 staff hours per week of mental health services.

Parent Center — the central location of the mental health center, at which most of the administrative, organizational, and clinical services are performed.

Professional Staff Member — a person trained in the discipline of psychiatry, clinical or counseling psychology, psychiatric social work, psychiatric nursing, counseling, or occupational therapy as described in 130 CMR 429.424.

Psychological Testing — the use of standardized test instruments to evaluate aspects of an individual's functioning, including aptitudes, educational achievements, cognitive processes, emotional conflicts, and type and degree of psychopathology, subject to the limitations of 130 CMR 429.441(H).

Satellite Facility — a mental health center program at a different location from the parent center that operates under the license of and falls under the fiscal, administrative, and personnel management of the parent center and that meets the following criteria.

(1) It is open to patients more than 20 hours a week.
(2) It offers more than 40 person hours a week of services to patients.

Short-Term Therapy — a combination of diagnostics and individual, couple, family, and group therapy planned to terminate within 12 sessions.

Supervised Clinical Experience — experience in providing diagnostic and treatment services in an organized mental health setting to individuals, families, and groups of individuals under the direct and continuing supervision of a professional qualified in psychiatry, clinical or counseling psychology, psychiatric social work, or psychiatric nursing.

429.403: Eligible Members

(A) (1) MassHealth Members. The Division covers mental health center services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

(2) Members of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

(C) For limitations on mental health and substance abuse services provided to members enrolled with a MassHealth managed care provider, see 130 CMR 450.124.

429.404: Provider Eligibility

(A) In State. Payment for the services described in 130 CMR 429.000 will be made only to mental health centers participating in MassHealth on the date of service. A center operated by a freestanding clinic, a satellite facility of a clinic, or an identifiable unit of a clinic, is eligible to participate only if the center is licensed by the Massachusetts Department of Public Health, is a Medicare-participating provider, and is certified by the Division for the provision of mental health services at that location. However, the Division may waive the clinic-licensure requirement for community health centers operated by local health departments that are thus exempt from licensure by the Massachusetts Department of Public Health under M.G.L. c. 111, s. 52, and that the Division has certified as performing community health center services.

(B) Out of State. To participate in MassHealth, an out-of-state mental health center must obtain a MassHealth provider number and meet the following criteria:

(1) if the center is required by its own state's law to be licensed, the center must be licensed by the appropriate state agency under whose jurisdiction it operates;
(2) the center must participate in its own state's medical assistance program or its equivalent;
(3) the center must be a Medicare-participating provider; and
(4) the center must have a rate of reimbursement established by the appropriate rate setting regulatory body of its state.

429.405: In-State Providers: Certification

(A) A center operated by a freestanding clinic, or an identifiable unit of a clinic, must meet the requirements listed in 130 CMR 429.421 through 429.441 in order to be certified by the Division. A center operated by a satellite facility of a freestanding clinic must meet all the requirements for certification as well as the additional requirements outlined in 130 CMR 429.439, except for a dependent satellite program that is exempt from full compliance with 130 CMR 429.421, subject to the conditions set forth in 130 CMR 429.439(D).

(B) A separate application for certification as a mental health center must be submitted for each parent center and satellite facility operated by the applicant. The application must be made on the form provided by the Division and must be submitted to the Division's Mental Health Center Program. The Division may request additional information from the applicant to evaluate the center's compliance with the regulations in 130 CMR 429.000.

(C) Based on the information revealed in the certification application and the findings of a site inspection, the Division will determine whether the applicant is certifiable or not. The Division will notify the applicant of the determination in writing within 60 days after the date of the site visit. If the Division determines that the applicant is not certifiable, the notice will contain a statement of the reasons for that determination, recommendations for corrective action, and an assessment of the applicant's prospects for certification, so that the applicant may reapply for certification once corrective action has been taken.

(D) The certification is valid only for the center described in the application and is not transferable to other centers operated at other locations by the applicant. Any additional center established by the applicant at a satellite facility must obtain separate certification from the Division in order to receive payment.

429.406: In-State Providers: Reporting Requirements

(A) All mental health centers must complete an annual report on forms furnished by the Division and file them with the Division within 90 days after the close of the Division's fiscal year. The report must include the current staffing pattern, indicate any revisions or changes in written policies and procedures, describe the role of the psychiatrist, and provide any other information that the Division may request.

(B) The Division may conduct a site visit to verify compliance with 130 CMR 429.000. If deficiencies are observed during such a site visit, the Division will send the center a letter itemizing these deficiencies. The center must then submit a plan of correction for all deficiencies cited in the letter, including the specific corrective steps to be taken, a timetable for these steps, and the date by which full compliance shall be achieved, which must be no later than three months after the date of the Division's letter. The Division will accept the plan of correction only if it conforms to these requirements.

(C) All centers must submit promptly to the Division the name and resume of any new clinical director or administrator. (See 130 CMR 429.423.)

(D) All centers must comply with all reporting requirements established under regulations of the Massachusetts Division of Health Care Finance and Policy.

429.407: In-State Providers: Revocation of Certification

(A) The Division has the right to review a mental health center's continued compliance with the conditions for certification referred to in 130 CMR 429.405 and the reporting requirements in 130 CMR 429.406 upon reasonable notice and at any reasonable time during the center's hours of operation. The Division has the right to revoke the certification, subject to any applicable provisions of the Division's administrative and billing regulations at 130 CMR 450.000, if such review reveals that the center has failed to or ceased to meet such conditions.

(B) If the Division determines that there exists good cause for the imposition of a lesser sanction than revocation of certification, it may withhold payment, temporarily suspend the center from participation in MassHealth, or impose some other lesser sanction as the Division sees fit.

429.408: In-State Providers: Maximum Allowable Fees

(A) The Massachusetts Division of Health Care Finance and Policy. The Massachusetts Division of Health Care Finance and Policy determines the maximum allowable fees for diagnostic and treatment services provided by mental health centers. Payment is subject to the conditions, exclusions, and limitations set forth in 130 CMR 429.000 and varies according to the type of provider. Reimbursement for a service provided by a mental health center will be the lower of the following:

(1) the maximum allowable fee listed in the mental health center fee schedule; or

(2) the center's usual and customary fee. In the event that the center has a sliding-scale charge structure, the maximum published charges will be considered the customary charges, providing that the following conditions are met:

(a) the center's full charges must be published in a fee schedule;

(b) the center's revenues must be based on the application of full charges with allowances noted for reduction of fees;

(c) the center's procedure for reduction of fees must be in accordance with written policies; and

(d) the center must maintain sufficient information to document the amount of the reductions.

(B) Administrative Operations. Payment by the Division for a mental health service includes payment for administrative operations and for all aspects of service delivery not explicitly included in 130 CMR 429.000, such as, but not limited to:

(1) patient registration;
(2) telephone contacts with members or other parties;
(3) supervision or consultation with another staff member;
(4) information and referral; and
(5) recordkeeping.

429.409: Out-of-State Providers: Maximum Allowable Fees

Payment to a mental health center located out of state is in accordance with the applicable rate schedule of its state's medical assistance program or its equivalent and is always subject to the applicable conditions, exclusions, and limitations set forth in 130 CMR 429.000.

429.410: Nonreimbursable Services

(A) Nonmedical Services. The Division does not pay mental health centers for nonmedical services. These services include, but are not limited to, the following:

(1) vocational rehabilitation services;
(2) sheltered workshops (a program of vocational counseling and training in which participants receive paid work experience or other supervised employment);
(3) educational services;
(4) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is reimbursable);
(5) street worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization); and
(6) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons).

(B) Nonmedical Programs. The Division does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other nonreimbursable services. Such programs include residential programs, day activity programs, drop-in centers, and educational programs.

(C) Research and Experimental Treatment. The Division does not pay for research or experimental treatment.

(D) Referrals. A provider to whom a member is referred must bill the Division directly, not through the mental health center. (See 130 CMR 429.411.)

429.411: Referrals

(A) All services provided by referral must be based on written agreements between the mental health center and the provider to whom a member is referred that ensure continuity of care, exchange of relevant health information, such as test results and records, and avoidance of service duplication. This agreement must also contain follow-up provisions to ensure that the referral process is completed successfully.

(B) The provider to whom a member is referred must bill the Division directly for all such referral services, not through the mental health center. In order to receive payment for referral services, the referral provider must be a participating provider in MassHealth on the date of service.

(130 CMR 429.412 through 429.420 Reserved)

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429.421: Scope of Services

(A) Requirements.

(1) A mental health center must have services available to treat a wide range of mental and emotional disorders, and it must provide comprehensive diagnostic assessments for a wide range of problems. In certain rare circumstances, the Division may waive the requirement that the center directly provide one or more of these services if the center has a written referral agreement with another source of care to provide such services, and makes such referrals according to the provisions of 130 CMR 429.411.

(2) All services must be clinically determined to be medically necessary and appropriate, and must be delivered by qualified staff in accordance with 130 CMR 429.424, and as part of the treatment plan in accordance with 130 CMR 429.432. These services are provided in intermittent sessions that ordinarily last less than two hours and are available on a walk-in or an appointment basis. Except for diagnostic and crisis intervention/emergency services, mental health centers must deliver all services to members with a psychiatric diagnosis and who function at a sufficient level to benefit from treatment.

(B) Diagnostic and Treatment Services. A center must have the capacity to provide at least the following diagnostic and treatment services, as defined in 130 CMR 429.402:

(1) diagnostic services;
(2) psychological testing;
(3) long-term therapy;
(4) short-term therapy;
(5) individual therapy;
(6) couple therapy;
(7) family therapy;
(8) group therapy;
(9) medication visit;
(10) case consultation;
(11) family consultation;
(12) crisis intervention/emergency services;
(13) after-hours telephone service. The telephone service must provide arrangements for effectively responding to the crisis. (A tape-recorded telephone message instructing patients to call a hospital emergency room is not acceptable.) Acceptable arrangements include:

(a) professional staff members available to talk to clients over the telephone and, if indicated, to arrange for further care and assistance directly or through referral; or

(b) an after-hours live telephone service and a referral arrangement with a local hospital emergency department or other emergency service, established through a written agreement that sets forth the policy, personnel, referral, coordination, and other procedural commitments as set forth in 130 CMR 429.411; and

(14) home visits.

429.422: Staff Composition Requirements

(A) The mental health center must have a balanced interdisciplinary staffing plan that includes three or more core professional staff members who meet the qualifications outlined in 130 CMR 429.424 for their respective professions. Of these, one must be a psychiatrist, and two must be from separate nonphysician core disciplines, including psychology, social work, or psychiatric nursing. Certain additional staffing requirements are contained in 130 CMR 429.423.

(B) The staff must have specific training and experience to treat the target populations of the center. For example, staff treating children are required to have specialized training and experience in children's services.

(C) For clinic-licensed mental health centers, the staff composition requirements are contained in 130 CMR 429.422 and 429.423. Clinic-licensed mental health centers must employ the equivalent of at least three full-time professional staff members, two of whom must be core team members who meet qualifications outlined in 130 CMR 429.423 for their respective disciplines. When a clinic-licensed mental health center has 10 employees or fewer, the core team members must work a minimum of 20 hours a week.

(D) Dependent satellite programs must employ at least two full-time equivalent professional staff members from separate nonphysician core disciplines. The Director of Clinical Services at the parent center must ensure that supervision requirements of 130 CMR 429.438(E) are performed. If the satellite program's staff do not meet the qualifications for core disciplines as outlined in 130 CMR 429.424, they must receive supervision from qualified core staff professionals of the same discipline at the parent center.

(E) For clinic-licensed community health centers, the center must employ at least two half-time professional staff members from separate, nonphysician core disciplines who meet the qualifications outlined in 130 CMR 429.424 for their respective disciplines.

(F) Autonomous satellite programs, as defined in 130 CMR 429.402, must meet the requirement's specified in 130 CMR 429.422(C).

429.423: Position Specifications and Qualifications

(A) Administrator. The mental health center must designate one individual as administrator, who is responsible for the overall operation and management of the center and for ensuring compliance with Division regulations. The administrator must have previous training or experience in personnel, fiscal, and data management, as described in 130 CMR 429.438.

(1) The same individual may serve as both the administrator and clinical director.

(2) In a community health center, the administrator of the entire facility may also administer the mental health center program.

(B) Director of Clinical Services. Mental health centers must designate a professional staff member to be the clinical director who is then responsible to the administrator for the direction and control of all professional staff members and services.

(1) The clinical director must be licensed, certified, or registered to practice in one of the core disciplines listed in 130 CMR 429.424, and must have had at least five years of full-time, supervised clinical experience subsequent to obtaining a master's degree, two years of which must have been in an administrative capacity. The clinical director must be employed on a full-time basis. When the clinic is licensed as a community health center, the clinical director must work at the center at least half-time.

(2) The specific responsibilities of the clinical director include:

(a) selection of clinical staff and maintenance of a complete staffing schedule;
(b) establishment of job descriptions and assignment of staff;
(c) overall supervision of staff performance;
(d) accountability for adequacy and appropriateness of patient care;
(e) in conjunction with the medical director, accountability for employing adequate psychiatric staff to meet the psychopharmalogical needs of clients;
(f) establishment of policies and procedures for patient care;
(g) program evaluation;
(h) provision of some direct patient care in circumstances where the clinical director is one of the three minimum full-time equivalent staff members of the center;
(i) development of in-service training for professional staff; and
(j) establishment of a quality management program.

(C) Medical Director. The mental health center must designate a psychiatrist who meets the qualifications outlined in 130 CMR 429.424(A) as the medical director, who is then responsible for establishing all medical policies and protocols and for supervising all medical services provided by the staff. The medical director must work at the center a minimum of eight hours a week. When the clinic is licensed as a community health center, the medical director must work at the center at least four hours a week.

(D) Psychiatrist.

(1) The roles and duties of administrator, director of clinical services, and medical director, as detailed in 130 CMR 429.423(A), (B), and (C), may be assumed, all or in part, by a psychiatrist on the center's staff, provided that provision of services to members and performance of all relevant duties in these regulations are carried out to meet professionally recognized standards of health care, as required by the Division's administrative and billing regulations at 130 CMR 450.000.

(2) The role of the psychiatrist in the center, apart from any duties that may be assumed under 130 CMR 429.423(A), (B), or (C), must include the following:

(a) responsibility for the evaluation of the physiological, neurological, and psychopharmacological status of the center's clients;
(b) involvement in diagnostic formulations and development of treatment plans;
(c) direct psychotherapy, when indicated;
(d) participation in utilization review or quality-assurance activity;
(e) coordination of the center's relationship with hospitals and provision of general hospital consultations as required;
(f) supervision of and consultation to other disciplines; and
(g) clinical coverage on an "on call" basis at all hours of center operation.

429.424: Qualifications of Staff by Core Discipline

(A) Psychiatrist.

(1) At least one staff psychiatrist must either currently be certified by the American Board of Psychiatry and Neurology, or be eligible and applying for such certification.
(2) Any additional psychiatrists must be, at the minimum, licensed physicians in their second year of a psychiatric residency program accredited by the Council on Medical Education of the American Medical Association. Such physicians must be under the direct supervision of a fully qualified psychiatrist.

(B) Psychologist.

(1) At least one staff psychologist must be licensed by the Massachusetts Board of Registration of Psychologists with a specialization listed in clinical or counseling psychology or a closely related specialty.
(2) Additional staff members trained in the field of clinical or counseling psychology or a closely related specialty must:

(a) have a minimum of a master's degree or the equivalent graduate study in clinical or counseling psychology or a closely related specialty from an accredited educational institution;
(b) be currently enrolled in or have completed a doctoral program in clinical or counseling psychology or a closely related specialty; and
(c) have had two years of full-time supervised clinical experience subsequent to obtaining a master's degree in a multidisciplinary mental health setting. (One year of supervised clinical work in an organized graduate internship program may be substituted for each year of experience.) All services provided by such additional staff members must be under the direct and continuing supervision of a psychologist meeting the requirements set forth in 130 CMR 429.424(B)(1).

(C) Social Worker.

(1) At least one staff social worker must have received a master's degree in social work from an accredited educational institution and must have had at least two years of full-time supervised clinical experience subsequent to obtaining a master's degree. This social worker must also be licensed or have applied for and have a license pending as an independent clinical social worker by the Massachusetts Board of Registration of Social Workers.

(2) Any additional social workers on the staff must provide services under the direct and continuous supervision of an independent clinical social worker. Such additional social workers must be licensed or applying for licensure as certified social workers by the Massachusetts Board of Registration of Social Workers and have received a master's degree in social work and completed two years of full-time supervised clinical work in an organized graduate internship program.

(D) Psychiatric Nurse.

(1) At least one psychiatric nurse must be currently registered by the Massachusetts Board of Registration in Nursing and must have a master's degree in nursing from an accredited National League of Nursing graduate school with two years of full-time supervised clinical experience in a multidisciplinary mental health setting and be eligible for certification as a clinical specialist in psychiatric/mental health nursing by the American Nursing Association.

(2) Any other nurses must be currently registered by the Massachusetts Board of Registration in Nursing and must have a bachelor's degree from an educational institution accredited by the National League of Nursing and two years of full-time supervised skilled experience in a multidisciplinary mental health setting subsequent to that degree, or a master's degree in psychiatric nursing.

(E) Counselor.

(1) All counselors and unlicensed staff included in the center must be under the direct and continuous supervision of a fully qualified professional staff member trained in one of the core disciplines described in 130 CMR 429.424(A) through (D).

(2) All counselors must hold a master's degree in counseling education, counseling psychology, or rehabilitation counseling from an accredited educational institution and must have had two years of full-time supervised clinical experience in a multidisciplinary mental health setting subsequent to obtaining the master's degree. (One year of supervised clinical work in an organized graduate internship program may be substituted for each year of full-time experience.)

(F) Occupational Therapist.

(1) Any occupational therapist must be currently registered by the American Occupational Therapy Association and must have:

(a) a master's degree in occupational therapy from an accredited program in occupational therapy; or

(b) a bachelor's degree in occupational therapy from an accredited program in occupational therapy and a master's degree in a related field such as psychology, social work, or counseling.

(2) In addition, any occupational therapist must have at least two years of full-time supervised clinical experience subsequent to obtaining a master's degree. (One year of supervised clinical work in an organized graduate internship program may be substituted for each year of full-time experience.)

(130 CMR 429.425 through 429.430 Reserved)

429.431: Operating Procedures

(A) A professional staff member must conduct a comprehensive evaluation of each member prior to initiation of therapy.

(B) The center must accept a member for treatment, refer the member for treatment elsewhere, or both, if the intake evaluation substantiates a mental or emotional disorder.

(C) One professional staff member must assume primary responsibility for each member (the primary therapist).

(D) The center program must make provisions for responding to persons needing services on a walk-in basis.

(E) The center must take appropriate steps to facilitate uninterrupted and coordinated member care whenever it refers a member elsewhere for treatment not available at the center or for subsequent treatment.

(F) Before referring a member elsewhere, the center must, with the member's consent, send a summary of or the actual record of the member to that referral provider prior to initiation of therapy.

429.432: Treatment Planning and Case Review

In conjunction with the primary therapist, a multidisciplinary team, composed of at least one psychiatrist and any two of the following: a psychologist, a social worker, or a psychiatric nurse (plus any other professional staff deemed appropriate) is responsible for conducting case conference meetings in accordance with the following:

(A) within four client visits, prepare a comprehensive written treatment plan that is based on the initial evaluation, incorporates short- and long-term treatment goals, and establishes criteria for determining when termination of treatment is appropriate;

(B) at least once every 90 days, review the member's treatment plan and enter into the member's records an updated statement of the problems, goals, and treatment activities and, if indicated, a reformulation of the treatment plan; and

(C) review each case at termination of treatment and prepare a termination summary that describes the course of treatment and the aftercare program or resources in which the member is expected to participate.

429.433: Coordination of Medical Care

A mental health center must coordinate psychotherapeutic treatment with medical care for MassHealth members. If a member has not received a physical exam within six months of the date of intake, the mental health center must advise the member that one is needed. If the member does not have an existing relationship with a physician, the mental health center must assist the member in contacting the Division's customer service toll-free line to receive help in selecting a physician. If the member does not want a physical examination, the member's record must document the member's preference and any stated reason for that preference.

429.434: Schedule of Operations

(A) There must be at least one location where a freestanding mental health center operates a program that is open at least 40 hours a week.

(B) A mental health center operated by a clinic-licensed community health center must be open at least 20 hours a week.

(C) When the center is closed, telephone coverage must be provided by personnel offering referral to operating emergency facilities, on-call clinicians, or other mechanisms for effectively responding to a crisis, in accordance with the requirements set forth at 130 CMR 429.421(B)(13).

429.435: Utilization Review Plan

The mental health center must have a utilization review plan that meets the following conditions.

(A) A utilization review committee must be formed, composed of the clinical director (or his or her designee), a psychiatrist, and one other professional staff member from each core discipline represented at the center who meets all the qualifications for the discipline, as outlined in 130 CMR 429.424.

(B) The utilization review committee must review each of the center's cases at least in the following circumstances:

(1) within 90 days of initial contact;
(2) when a member has required more than 50 visits every 12 months and has not required hospitalization or extensive crisis intervention during that period; and
(3) following termination.

(C) The utilization review committee must verify for each case that:
(1) the diagnosis has been adequately documented;
(2) the treatment plan is appropriate and specifies the methods and duration of the projected treatment program;
(3) the treatment plan is being or has been carried out;
(4) the treatment plan is being or has been modified as indicated by the member's changing status;
(5) there is adequate follow-up when a member misses appointments or drops out of treatment; and
(6) there is progress toward achievement of short- and long-term goals.

(D) No staff member can participate in the utilization review committee's deliberations about any member he or she is treating directly.

(E) The mental health center must maintain minutes that are sufficiently detailed to show the decisions of each review and the basis on which any decisions are made so that the Division may conduct such audits as it deems necessary.

(F) Based on the utilization review, the director of clinical services or his or her designee must determine whether continuation, modification, or termination of treatment is necessary and promptly communicate this decision to the primary therapist.

429.436: Recordkeeping Requirements

(A) A mental health center must maintain on its premises either the original record or a microfilm of the original record for each member for a period of at least four years following the date of service. When a member is transferred from a mental health center that is a component of a community health center to an independent agency affiliated with the community health center, the mental health center itself must retain a copy of the member's record if it forwards the record to the affiliated agency.

(B) The center must obtain written authorization from each member or his or her legal guardian to release information obtained by the center to center staff, federal and state regulatory agencies, and, when applicable, referral providers, to the extent necessary to carry out the purposes of the center program and to meet regulatory requirements. All such information must be released on a confidential basis.

(C) Each member's record must include the following information:
(1) the member's name and case number, MassHealth identification number, address, telephone number, sex, age, date of birth, marital status, next of kin, school or employment status (or both), and date of initial contact;

(2) a report of a physical examination performed within six months of the date of intake or documentation that the member did not want to be examined and any stated reason for that preference;
(3) the name and address of the member's primary care physician or, if not available, another physician who has treated the member;
(4) the member's description of the problem, and any additional information from other sources, including the referral source, if any;
(5) the events precipitating contact with the center;
(6) the relevant medical, psychosocial, educational, and vocational history;
(7) a comprehensive functional assessment of the member at intake and semi-annually thereafter;
(8) the clinical impression of the member and a diagnostic formulation, including a specific diagnosis using standard nomenclature;
(9) a listing of realistic long-range goals, and a time frame for their achievement;
(10) a listing of short-term objectives, which must be established in such a way as to lead toward accomplishment of the long-range goals;
(11) the proposed schedule of therapeutic activities, both in and out of the center, necessary to achieve such goals and objectives and the responsibilities of each individual member of the interdisciplinary team;
(12) a schedule of dates for utilization review to determine the member's progress in accomplishing goals and objectives;
(13) the name, qualifications, and discipline of the therapist primarily responsible for the member;
(14) a written record of quarterly reviews by the primary therapist, which relate to the short- and long-range goals;
(15) progress notes on each visit written and signed by the primary therapist that include the therapist's discipline and degree, as well as notes by other professional staff members significantly involved in the treatment plan;
(16) all information and correspondence regarding the member, including appropriately signed and dated consent forms;
(17) a medication-use profile; and
(18) when the member is discharged, a discharge summary, including a recapitulation of the member's treatment and recommendations for appropriate services concerning follow-up as well as a brief summary of the member's condition and functional performance on discharge.

(D) A brief history is acceptable for emergency or walk-in visits when the treatment plan does not call for extended care.

429.437: Written Policies and Procedures

A mental health center must have and observe written policies and procedures that include:

(A) a statement of its philosophy and objectives;

(B) criteria for client admission;

(C) a statement of the geographical area served;

(D) an intake policy;

(E) treatment procedures, including, but not limited to, development of the treatment plan, case assignment, case review, discharge planning, and follow-up on clients who leave the program without notice;

(F) a medication policy that includes prescription, administration, and monitoring data;

(G) a referral policy, including procedures for ensuring uninterrupted and coordinated client care upon transfer;

(H) procedures for walk-in clients and clinical emergencies during operating and nonoperating hours;

(I) a records policy, including what information must be included in each record, and procedures to ensure confidentiality;

(J) supervisory mechanisms for staff;

(K) a utilization review plan; and

(L) explicit fee policies with respect to billing third-party payers and clients, cancellation procedures, and fee reductions.

429.438: Administration

The mental health center must be organized to facilitate effective decision-making by appropriate personnel on administrative, programmatic, and clinical issues.

(A) Organization. The center must establish an organization table showing major operating programs of the facility, with staff divisions, administrative personnel in charge of each program, and their lines of authority, responsibility, and communication.

(B) Fiscal Management. The center must establish a system of business management to ensure accurate accounting for sources and uses of funds and proper expenditure of funds within established budgetary constraints and grant restrictions.

(C) Data Management. The center must develop and maintain a statistical information system to collect client, service utilization, and fiscal data necessary for the effective operation of the center.

(D) Personnel Management. The center must establish and maintain personnel policies and personnel records for each employee.

(E) Supervision.

(1) Each staff member must receive supervision appropriate to the person's skills and level of professional development. Supervision must occur within the context of a formalized relationship providing for frequent and regularly scheduled personal contact with the supervisor. Frequency and extent of supervision must conform to the licensing standards of each discipline's Board of Registration, as cited in 130 CMR 429.424.

(2) The center must establish and implement procedures for staff training and evaluation.

429.439: Satellite Programs

Services provided by a satellite program are reimbursable only if the program meets the standards described below.

(A) A satellite program must be integrated with the parent center in the following ways.

(1) The administrator of the parent center is responsible for ensuring compliance of the satellite program with the regulations in 130 CMR 429.000.

(2) There must be clear lines of supervision and communication between personnel of the parent center and its satellite programs. The parent center must maintain close liaison with its satellite programs through conferences or other methods of communication.

(3) The satellite program must be subject to all the written policies and procedures of the parent center governing the types of services that the satellite program offers.

(4) The satellite program must maintain on its own premises its client records as set forth in 130 CMR 429.436.

(B) An autonomous satellite program must provide supervision and in-service training to all noncore staff employed at the satellite program.

(C) The director of clinical services of the parent center must designate one professional staff member at the satellite program as the satellite's clinical director. The clinical director must be employed on a full-time basis and meet all of the requirements in 130 CMR 429.423(B).

(1) The supervisor of the satellite program must report regularly to the clinical director of the parent center to ensure ongoing communication and coordination of services.

(2) In an autonomous satellite program, the supervisor must meet the qualifications required of a core staff member in his or her discipline, as set forth in 130 CMR 429.424.
(3) In a dependent satellite program, the supervisor must meet the basic qualifications required for his or her discipline, as set forth in 130 CMR 429.424, and receive regular supervision and consultation from qualified core staff at the parent center.

(D) If a dependent satellite program does not offer the entire range of services available at the parent center, the dependent satellite program must refer clients to the parent center or a facility that offers such services. The parent center must determine the necessity for treatment and the appropriateness of the treatment plan for such clients and institute a clear mechanism through which this responsibility is discharged, by consultation with the satellite program team, regular supervision of the satellite program by supervisory-level professional core staff in the parent center, or by other appropriate means. For staff composition requirements pertaining to dependent satellite programs, see 130 CMR 429.422(D).

429.440: Outreach Programs

An outreach program operated by a mental health center is eligible for payment if it meets the standards described below.

(A) Outreach program staff members must receive supervision and in-service training in accordance with the requirements specified in 130 CMR 429.438(E).

(B) The director of clinical services must meet at least on a monthly basis with outreach program staff members and have direct contact with outreach program clients as necessary to provide medical diagnosis, evaluation, and treatment in accordance with the requirements outlined in 130 CMR 429.423(B).

(C) Outreach programs must maintain the records of their clients on the premises of the parent center.

(D) Outreach programs must be subject to all written policies and procedures of the parent center governing the kinds of services that the outreach program offers.

(E) Outreach programs must meet the requirements of 130 CMR 429.439(D) applicable to dependent satellite programs.

(F) Outreach program services must conform to the definition in 130 CMR 429.402.

(G) Services provided at outreach programs are subject to the requirements in 130 CMR 429.431, 429.432, and 429.435.

429.441: Service Limitations

(A) Length and Frequency of Sessions.

(1) The Division pays for diagnostic and treatment services only when a professional staff member, as defined by 130 CMR 429.424, personally provides these services to the member or the member's family, or personally consults with a professional outside of the center. The services must be provided to the member on an individual basis, and are not reimbursable if they are an aspect of service delivery, as defined in 130 CMR 429.408(C).

(2) The Division pays a center for:

(a) a medication visit of brief duration (10 to 15 minutes);

(b) a half-hour session only when it includes a minimum of 25 minutes of personal interaction with the member (with five minutes for recording data);

(c) a one-hour session only when it includes a minimum of 50 minutes of personal interaction with the member (with 10 minutes for recording data); and

(d) a session of longer duration only when it includes personal interaction with the member (with 15 minutes for recording data).

(3) The Division pays for only one session of a single type of service (except for diagnostics) provided to an individual member on one date of service. Return visits on the same date of service are not reimbursable.

(B) Diagnostic Services. Payment for diagnostic services provided to a member is limited to a maximum of four hours per member.

(C) Individual Therapy. Payment for individual therapy is limited to a maximum of one hour per member per session per day.

(D) Family Therapy.

(1) Payment for family therapy is limited to a maximum of one and one-half hours per session per day.

(2) Payment is also limited to one payment per family therapy visit, regardless of the number of staff or members who are present.

(3) A clinic-licensed center must claim payment for couple therapy under the service code for family therapy.

(E) Case Consultation.

(1) The Division pays only for a case consultation that lasts at least 30 minutes and involves a personal meeting with a professional of another agency. Payment is limited to a maximum of one hour per session.

(2) The Division pays for case consultation only when telephone contact, written communication, and other nonreimbursable forms of communication clearly will not suffice. Such circumstances must be documented in the member's record. Such circumstances are limited to situations in which both the center and the other party are actively involved in treatment or management programs with the member (or family members) and where a lack of face-to-face communication would impede a coordinated treatment program.

(3) The Division does not pay a center for court testimony.

(F) Family Consultation. The Division pays for consultation with the natural or foster parent or legal guardian of a member less than 21 years of age who lives with the child and is responsible for the child's care, and who is not an eligible member, when such consultation is integral to the treatment of the member.

(G) Group Therapy.

(1) The Division pays only for a group therapy session that has a minimum duration of one and one-half hours and a maximum duration of two hours.

(2) Payment is limited to one fee per group member with a maximum of 10 members per group regardless of the number of staff members present.

(3) The Division does not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(H) Psychological Testing. The Division pays a center for psychological testing only when the following conditions are met.

(1) A psychologist who meets the qualifications listed in 130 CMR 429.424(B) either personally administers the testing or personally supervises such testing during its administration by an unlicensed psychologist.

(2) A battery of tests is performed. These tests must meet the following standards:

(a) the tests are published, valid, and in general use, as evidenced by their review in the current edition of the *Mental Measurement Yearbook* or by their conformity to the *Standards for Educational and Psychological Tests* of the American Psychological Association;

(b) unless clinically contraindicated due to hearing, physical, or visual impairment or linguistic challenges, a personality evaluation contains the findings of at least two of the following test types or their age-appropriate equivalents: Rorschach, TAT (Thematic Apperception Test), TED (Tasks of Emotional Development), or MMPI (Minnesota Multiphasic Personality Inventory), and one or more of the following test types: figure drawing, Bender Gestalt, or word association;

(c) unless clinically contraindicated due to hearing, physical, or visual impairment or linguistic challenges, intelligence testing includes either a full Wechsler or Stanford-Binet instrument; and

(d) unless clinically contraindicated due to hearing, physical, or visual impairment or linguistic challenges, assessment of brain damage must contain at least the findings of a Wechsler Intelligence Scale and tests of recent memory, visual-space perception, and other functions commonly associated with brain damage.

(3) Except as explained below, the Division does not pay for:

(a) self-rating forms and other paper-and-pencil instruments, unless administered as part of a comprehensive battery of tests;

(b) group forms of intelligence tests; or

(c) a repetition of any psychological test or tests provided by the mental health center or any independent psychologist to the same member within the preceding six months, unless accompanied by documentation demonstrating that the purpose of the repeated testing is to ascertain the following types of changes (submission of such documentation with the claim for payment is sufficient when the psychological test or tests are to be performed on the same member a second time within a six-month period):

(i) following such special forms of treatment or intervention as electroshock therapy or psychiatric hospitalization (periodic testing to measure the member's response to psychotherapy is not reimbursable); or

(ii) relating to suicidal, homicidal, toxic, traumatic, or neurological conditions.

(4) Testing of a member requested by responsible parties, such as but not limited to physicians, clinics, hospitals, schools, courts, group homes, or state agencies, must be documented in the member's record. Such documentation must include the referral source and the reason for the referral.

(I) Medication Visits. The Division does not pay for a medication visit as a separate service when it is performed as part of another treatment service (for example, a diagnostic assessment or individual or group therapy performed by a psychiatrist).

(J) Home Visits.

(1) The Division pays for intermittent home visits.

(2) Home visits are reimbursable on the same basis as comparable services provided at the center. Travel time to and from the member's home is not a reimbursable service.

(3) A report of the home visit must be entered into the member's record.

(K) Multiple Therapies. The Division pays for more than one mode of therapy used for a member during one week only if clinically justified; that is, when any single approach has been shown to be necessary but insufficient. The need for additional modes of treatment must be documented in the member's record.

(L) Emergency Services. The Division pays for crisis intervention as defined in 130 CMR 429.402 subject to the following limitations.

(1) The Division pays for no more than two hours of emergency services per member on a single date of service.

(2) The Division pays only for face-to-face contacts; telephone contact is not a reimbursable service.

(3) The need for crisis intervention must be fully documented in the member's record for each date of emergency services.

(M) Outreach Services Provided in Nursing Facilities.

(1) The Division pays a center for diagnostic and treatment services provided to a member residing in a nursing facility under the following circumstances and conditions:

(a) the nursing facility specifically requests treatment, and the member's record at the nursing facility documents this request;

(b) the treatment provided does not duplicate services that should be provided in the nursing facility; and

(c) such services are generally available through the center to members not residing in that nursing facility.

(2) The following conditions must be met:

(a) the member's record at the parent center must contain all of the information listed in 130 CMR 429.436;

(b) the member's record at the nursing facility must contain information pertaining to diagnostic and treatment services including, but not limited to, medication, treatment plan, progress notes on services, case review, and utilization review; and

(c) the member must function at a sufficient level to benefit from treatment as established by a clinical evaluation and by accepted standards of practice.

REGULATORY AUTHORITY

130 CMR 429.000: M.G.L. c. 118E, ss. 7 and 12.